



NTSB National Transportation Safety Board

**Improved
Productivity and Safety
Through Better
Collaboration and
Prioritization:
*Lessons Learned in
Aviation***

Presentation to:

Riverside EMS Agency

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The Contrast

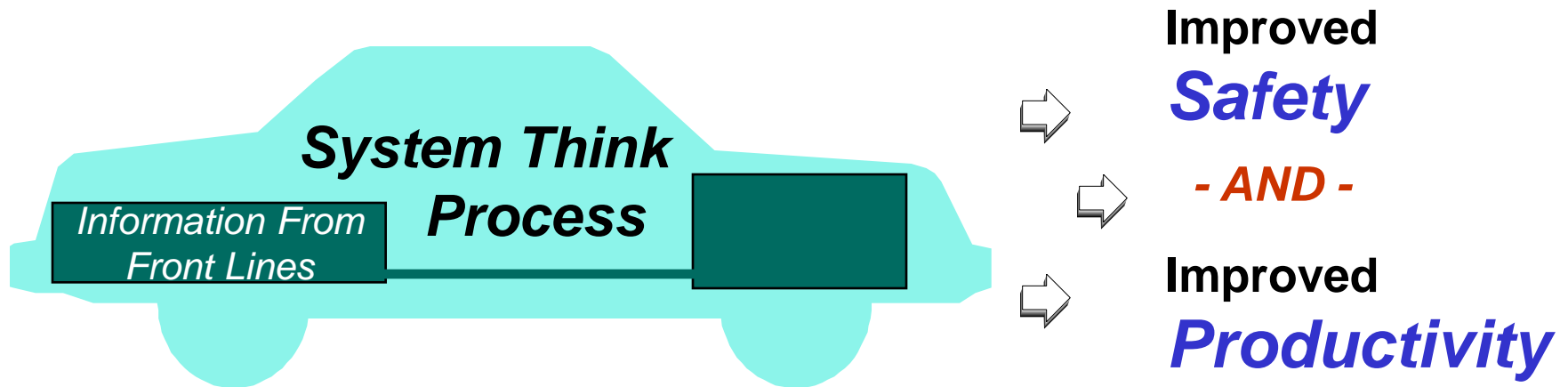
- **Conventional Wisdom:**

Improvements that reduce risk
also usually reduce productivity

- **Lesson Learned from Proactive Aviation Safety Programs:**

Risk can be reduced in a collaborative way that also
results in *immediate productivity improvements*

Process Plus Fuel Creates A Win-Win



Outline

- The Context**
- Importance of “System Think”**
- Importance of Better Information**
- Safety and Productivity Benefits**
- Roles of Leadership and Regulator**
- Prioritization Challenges**

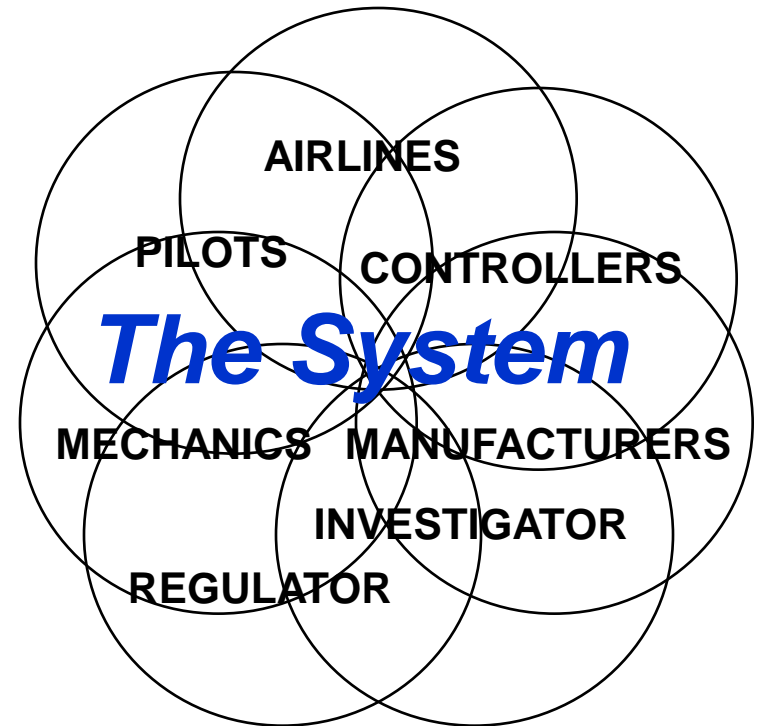
NTSB 101

- Independent federal agency, investigate transportation mishaps, all modes
- Determine probable cause(s) and make recommendations to prevent recurrences
- Primary product: Safety recommendations
 - Favorable response > 80%
- ***SINGLE FOCUS IS SAFETY***
- Independence
 - Political: Findings and recommendations based upon evidence rather than politics
 - Functional: No “dog in the fight”



The Context: Increasing Complexity

- **More System**
Interdependencies
 - Large, complex, interactive system
 - Often tightly coupled
 - Hi-tech components
 - Continuous innovation
 - Ongoing evolution
- **Safety Issues Are More Likely to Involve**
Interactions Between Parts of the System



Effects of Increasing Complexity:

More “Human Error” Because

- **System More Likely to be Error Prone**
- **Operators More Likely to Encounter Unanticipated Situations**
- **Operators More Likely to Encounter Situations in Which “By the Book” May Not Be Optimal (“workarounds”)**

The Result:

Front-Line Staff Who Are

- Highly Trained
- Competent
- Experienced,
- Trying to Do the Right Thing, and
- Proud of Doing It Well

. . . Yet They Still Commit

**Inadvertent
Human Errors**

The Solution: System Think

***Understanding how a
change in one subsystem
of a complex system may
affect other subsystems
within that system***

“System Think” via Collaboration

Bringing all parts of a complex system together to collaboratively

- **Identify potential issues**
- ***PRIORITIZE* the issues**
- **Develop solutions for the prioritized issues**
- **Evaluate whether the solutions are**
 - **Accomplishing the desired result, and**
 - **Not creating unintended consequences**

When Things Go Wrong

How It Is Now . . .

You are highly trained

and

If you did as trained, you
would not make mistakes

so

You weren't careful
enough

so

You should be **PUNISHED!**

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the
system allowed, or failed to
accommodate, your mistake

and

Let's **IMPROVE THE SYSTEM!**

Fix the Person or the System?

Is the **Person**
Clumsy?

Or Is the
Problem . . .

The **Step???**



Enhance Understanding of Person/System Interactions By:

- Collecting,**
 - Analyzing, and**
 - Sharing**
- # **Information**

Objectives:

Make the System

***(a) Less
Error Prone***

and

***(b) More
Error Tolerant***

The Health Care Industry

To Err Is Human:

Building a Safer Health System

“The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.”

Institute of Medicine, Committee on Quality of Health Care in America, 1999



Major Source of Information: Hands-On “Front-Line” Employees

**“We Knew About
That Problem”**

***(and we knew it might hurt
someone sooner or later)***

Next Challenge



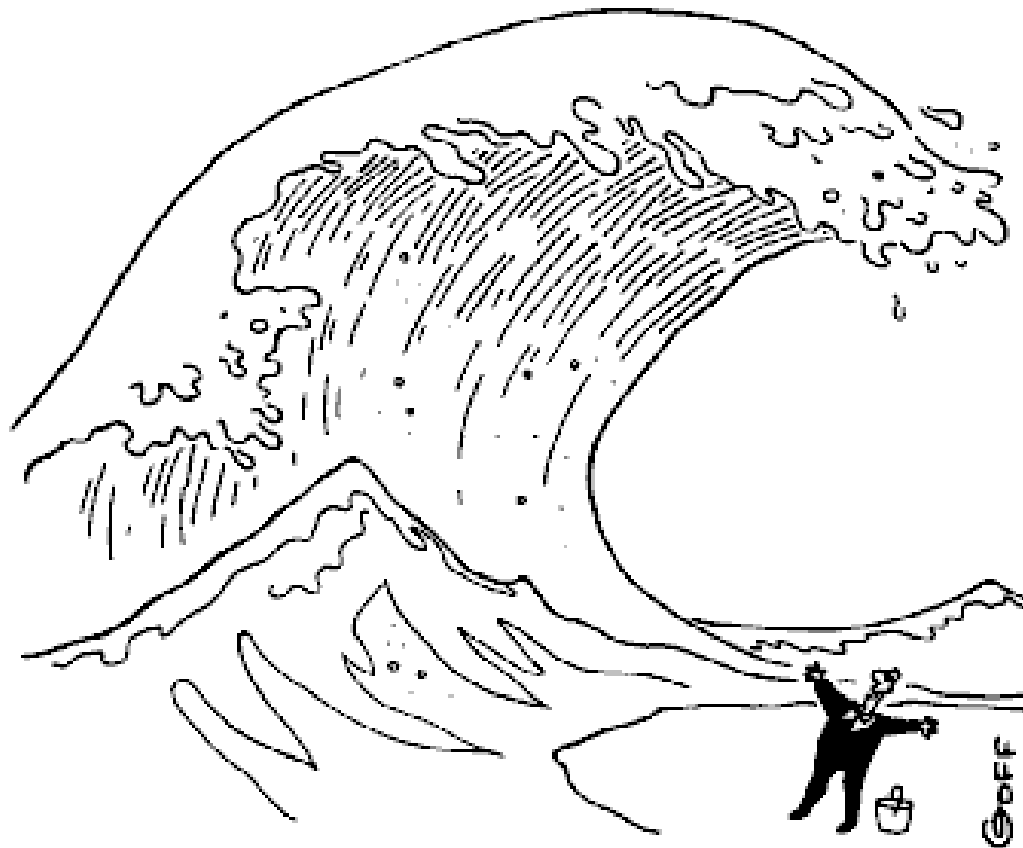
Legal/Cultural Issues

Improved Analytical Tools

As we begin to get over the first hurdle, we must start working on the next one . . .

Information Overload

© 1996 Ted Goff



"EUREKA! MORE INFORMATION!"

From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA



Analysts

USEFUL

INFORMATION

Smart Decisions

- Identify issues
- **PRIORITIZE!!!**
- Develop solutions
- Evaluate interventions

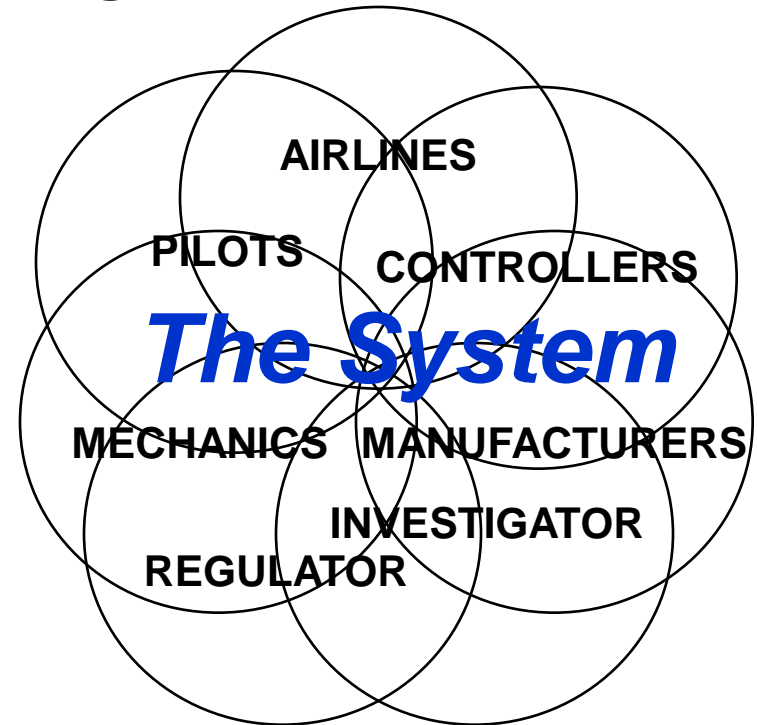
Tools

Processes



Aviation “System Think” Process

- Engage All Participants In Identifying Problems and Developing and Evaluating Remedies
- Airlines
- Manufacturers
 - *With the systemwide effort*
 - *With their own end users*
- Air Traffic Organizations
- Labor
 - *Pilots*
 - *Mechanics*
 - *Air traffic controllers*
- Regulator(s) [Query: Investigator(s)?]



Success Story

65% Decrease in Fatal Accident Rate,
1997 - 2007

largely because of
System Think

fueled by
***Proactive Safety
Information Programs***

P.S. Aviation was already considered **VERY SAFE** in 1997!!



Moral of the Story

Anyone who is
involved in the *problem*
should be involved in
developing the *solution*

Collaboration: A Major Paradigm Shift

- **Old: Regulator identifies a problem and proposes solutions**
 - Industry skeptical of regulator's understanding of the problem
 - Industry resists regulator's solutions and/or implements them begrudgingly
- **New: Collaborative “System Think”**
 - Industry involved in identifying problem
 - Industry “buy-in” re interventions because everyone had input, everyone's interests considered
 - Prompt and willing implementation
 - Interventions evaluated . . . *and tweaked as needed*
 - Solutions probably more effective and efficient
 - Unintended consequences much less likely



Challenges of Collaboration

- Human nature: “I’m doing great . . . *the problem is everyone else*”
- Differing and sometimes competing interests
 - Labor-management issues
 - May be potential co-defendants
- Regulator probably not welcome
- Not a democracy
 - Regulator must regulate
- Requires all to be willing, in their *enlightened self-interest*, to leave their “comfort zone” and think of the System



System Think at Other Levels

- **“System Think” can be successful at any macro/micro level, including**
 - Entire industry
 - Company (some or all)
 - Type of activity
 - Facility
 - Team
- **Persistent workplace problem?**



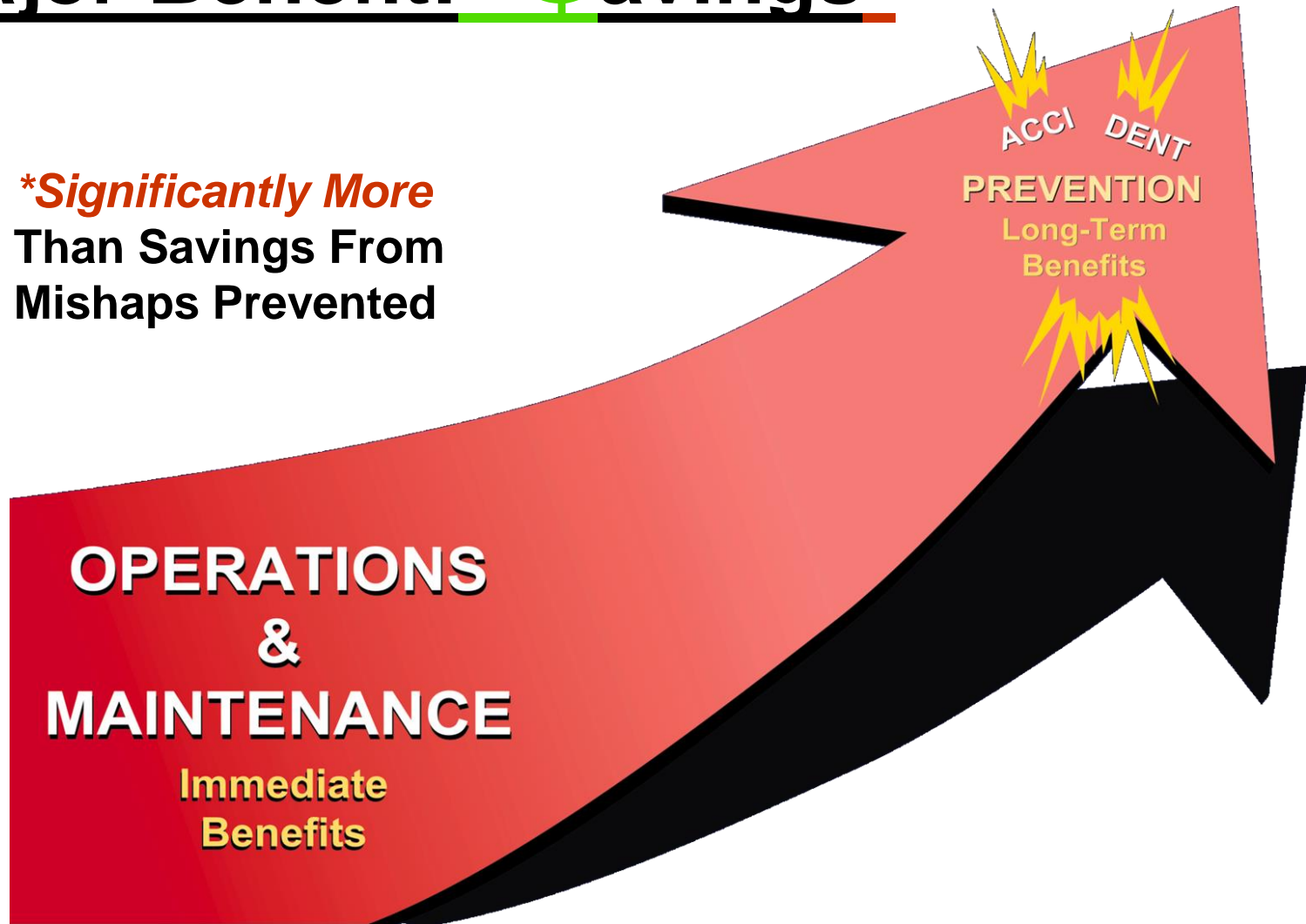
Manufacturer Level “System Think”

Aircraft manufacturers are increasingly seeking input, from the earliest phases of the design process, from

- *Pilots* (User Friendly)
- *Mechanics* (Maintenance Friendly)
- *Air Traffic Services* (System Friendly)

Major Benefit: **\$avings***

**Significantly More*
Than Savings From
Mishaps Prevented



Safety/Productivity Success Stories

- **Ground Proximity Warning System**
 - *S: Reduced warning system complacency*
 - *P: Reduced unnecessary missed approaches, saved workload, time, and fuel*
- **Flap Overspeed**
 - *S: No more potentially compromised airplanes*
 - *P: Significantly reduced need to take airplanes off line for **VERY EXPENSIVE (!!) disassembly, inspection, repair, and reassembly***



But Then . . .

Why Are We

So Jaded in The Belief That

Improving Safety

Will Probably

Hurt The Bottom Line??

Costly Result\$ Of Safety Improvements Poorly Done

Safety **Poorly** Done

1. Punish/re-train operator

- *Poor workforce morale*
- *Poor labor-management relations*
- *Labor reluctant to tell management what's wrong*
- *Retraining/learning curve of new employee if “perpetrator” moved/fired*
- *Adverse impacts of equipment design ignored, problem may recur because manufacturers are not involved in improvement process*
- *Adverse impacts of procedures ignored, problem may recur because procedure originators (management and/or regulator) are not involved in improvement process*

Safety **Well** Done

Look beyond operator,
also consider system
issues



Costly Result\$ Of Safety Poorly Done (con't)

Safety **Poorly** Done

2. Management decides remedies unilaterally

- *Problem may not be fixed*
- *Remedy may not be most effective, may generate other problems*
- *Remedy may not be most cost effective, may reduce productivity*
- *Reluctance to develop/implement remedies due to past remedy failures*
- *Remedies less likely to address multiple problems*

3. Remedies based upon instinct, gut feeling

- *Same costly results as No. 2, above*

Safety **Well** Done

Apply “System Think,” *with workers*, to identify and solve problems

Remedies based upon evidence (including info from front-line workers)



Costly Result\$

Of Safety Poorly Done (con't)

Safety **Poorly** Done

4. Implementation is last step

- *No measure of how well remedy worked (until next mishap)*
- *No measure of unintended consequences (until something else goes wrong)*

Safety **Well** Done

Evaluation after implementation

Query: Is Safety Good Business?

- *Safety implemented poorly can be **very costly (and ineffective)***
- *Safety implemented well, in addition to improving safety more effectively, can also **create benefits greater than the costs***



The Role of Leadership

- Demonstrate Safety Commitment . . .

But Acknowledge That Mistakes Will Happen

- Include “Us” (e.g., System) Issues,

Not Just “You” (e.g., Training) Issues

- **Make Safety a Middle Management Metric**

- Engage Labor Early

- Include the **System** --

Manufacturers, Operators, Regulator(s), and Others

- Encourage and Facilitate Reporting

- Provide **Feedback**

- Provide Adequate **Resources**

- **Follow Through** With Action



How The Regulator Can Help

- Emphasize the importance of System issues *in addition to (not instead of)* worker issues
- Encourage and participate in industry-wide “System Think”
- Facilitate collection and analysis of information
 - Clarify and announce *policies for protecting information and those who provide it*
 - Encourage other industry participants to do the same
- Recognize that *compliance* is very important, but the *mission is reducing systemic risk*

Next Challenge: Prioritization

You will probably identify *more potential concerns* than you have resources to address

Cost to address potential concern 1
+ Cost to address potential concern 2
+ Cost to address potential concern 3
+ . . .
+ . . .
+ . . .
+ Cost to address potential concern “n”
Total: More than available resources

So . . . how to decide, *BEFORE* a mishap (i.e., *WITHOUT* the benefit of 20-20 hindsight), what to fix first?

Factors to Consider

- Severity and likelihood – past, present, and future**
 - Cost of remedy**
 - Synergies of concern with other concerns?**
 - Synergies of remedy with other concerns/remedies?**
 - Other?**
-
- Process question: First in, first out?**

Examples of Prioritization Failures?

How many *other pressing issues* (if any) were being addressed when:

- **NASA** responded inadequately to previous events of separated foam that struck the orbiter during launch
- **Concorde** manufacturer and operators responded inadequately to previous tire disintegrations during takeoff
- **Ford and Firestone** responded inadequately to previous tire failures and rollovers in Ford Explorers
- The **intelligence community** responded inadequately to reports about people who wanted to learn to fly – but not how to land – in an airline flight simulator

Missing Element – The Harsh Glare of Hindsight



Is Prioritization Working?

- Process can never be perfect
 - Depends heavily upon predictions and judgment calls
 - Particularly difficult in high-tech or otherwise continually changing operations
- Success may be difficult to measure
 - Prioritization process may help prevent the **worst** or **most frequent** adverse events, but not necessarily **every** adverse event
 - Thus, when adverse events keep happening, how to determine if the process is working?

So . . . Collaboration for EMS?

- Select troublesome area**
 - Nagging problem for many years
 - Many interventions have been tried, not successful
 - Likelihood that problems are systemic, not just people
 - Effort to address the system problems
 - Less defensiveness because not focused on single event
- Select collaborative corrective action group**
 - All who have a hand in the process
 - Manufacturers?
 - Regulators?
 - Patients?



Thank You!!!



Questions?